

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 1/14/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2010
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OVERTON COUNTY NURSING HOME

318 BILBREY STREET

LIVINGSTON, TN 38570

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>An annual recertification survey and complaint investigation #26610 and #27122 were completed on November 30 - December 2, 2010, at Overton County Nursing Home. No deficiencies were cited related to complaint investigation #26610 under 42 CFR PART 482, Requirements for Long Term Care. Deficiencies were cited related to complaint investigation #27122.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to update the care plan to reflect changes in resident care for three residents (#6,</p>	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Administrator

12-16-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 PRINTED: 12/08/2010
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F 280	<p>Continued From page 1</p> <p>#26, #8) of twenty-six residents reviewed.</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on November 5, 2010, and readmitted on November 23, 2010, with diagnoses including Respiratory Failure, Deep Venous Thrombosis, Alcohol Abuse, Supraventricular Tachycardia, Hepatitis B, and Failure to Thrive.</p> <p>Observation of the resident's room during the initial tour on November 30, 2010, at 10:00 a.m., revealed a red biohazard bag in the trash can and a biohazard bag in the linen hamper. Continued observation of the room revealed no signage to indicate the resident was on isolation.</p> <p>Further medical record review revealed no nursing care plan present in the record to reflect the resident's need for isolation precaution or specific precautions to be observed with resident care.</p> <p>Interview with the Director of Nursing (DON) on December 2, 2010, at 9:30 a.m., in the DON's office, revealed the resident was on contact isolation for Hepatitis B and confirmed there was no care plan in the record and no documentation of the need for contact isolation precautions.</p> <p>Resident #26 was admitted to the facility on November 4, 2010, with diagnoses including Congestive Heart Failure, Coronary Artery Disease, Coronary Artery Bypass Graft, Diabetes Mellitus, Hypertension, Gastroesophageal Reflux Disease, and Transient Ischemic Attack.</p>	F 280	<p>Changes in resident care was immediately updated for all three residents to their care plans reflecting the need for isolation precautions and/or any specific precautions to observe for the residents. The MDS co-ordinator received physician orders and updated care plans for residents #6, #26, and #8.</p> <p>The facility procedure has been updated to include obtaining physician orders for contact isolation and updating the care plans to reflect the need for isolation precautions with the residents. This policy was placed into facility use on 12/8/2010. Staff was in-serviced and policy manual updated on 12/8/2010.</p>	12/8/2010	

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F 280	<p>Continued From page 2</p> <p>Medical record review of a nursing note dated November 21, 2010 at 4:00 p.m., revealed "Wound care done to posterior thigh. Dark red, purple area approx (approximately) 10 cm (centimeters) x 10 cm. Has area in center 2.5 cm x 2.5 cm with 2 pinpoint open areas with thick yellow drainage." Further medical record review of a nursing note dated November 23, 2010, at 8:50 a.m., revealed "...wound culture of resident received with MRSA (Methicillin Resistant Staphylococcus Aureus) in wound."</p> <p>Observation of the resident's room during initial tour on November 30, 2010, at 10:15 a.m., revealed no sign on the door indicating the resident was on contact isolation.</p> <p>Medical record review revealed no nursing care plan in the record to reflect the resident's need for isolation precautions or specific precautions to be observed with dressing changes.</p> <p>Interview with the DON on December 2, 2010, at 9:30 a.m., in the DON's office, confirmed the resident was on contact isolation for MRSA and there was no nursing care plan in the record or documentation of the need for contact isolation precautions.</p> <p>Resident #8 was admitted to the facility on August 2, 2010, with diagnoses including Cervical Spinal Stenosis, Hypertension, and Cerebral Vascular Accident.</p> <p>Medical record review of the Fall Risk Assessment dated August 2, 2010, revealed the resident at risk for falls.</p> <p>Medical record review of the Assisted Transfer</p>	F 280	<p>The Director of Nursing and Quality Assurance Nurse will monitor infections through the infection monitor sheet and charge nurses have been in-serviced to notify the QA nurse when any new infection arises that is communicable. This will ensure that all infection control measures are in place.</p> <p>Tracking of facility infections will continue with the Director of Nursing and the QA meeting will discuss the adherence to new procedure for contact isolation precautions for the quality assurance program in facility. The facility will include Infection Control in the Safety In-Services and meetings.</p> <p>CDC guidelines state that the 'combination of infection control and a safety campaign is more effective in retention of proper technique and procedure for contact isolation then addressing it singularly' with blood borne pathogen instruction or infection control instruction. (CDC guidelines I.D.2.a. for Long Term Care Facilities)</p>	12/8/2010	

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F 280	Continued From page 3 Policy revealed "...If the resident cannot stand alone, two persons (one on each side) should assist the resident to stand using a gait belt, and turn the resident and sit him/her in the chair..." Medical record review of the Care Plan dated August 11, 2010, revealed no documentation addressing the use of a gait belt with transfers. Interview with MDS/Care Plan Coordinator, on December 2, 2010, at 1:15 p.m., in the MDS/Care Plan Coordinator's office, confirmed the care plan had not been revised to reflect the use of a gait belt for transfers.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to implement a transfer device for one resident (#8) of twenty-six residents reviewed. The findings included: Resident #8 was admitted to the facility on August 2, 2010, with diagnoses including Cervical Spinal Stenosis, Hypertension, and Cerebral Vascular Accident.	F 323	Resident # 8 care plan was immediately updated to reflect the use of gait belt with transfers with the resident. The MDS co-ordinator will update care plans to include the need for assistive devices with residents per our facility policy. The QA nurse will monitor this using an audit of a selection of charts with residents using assistive devices. This will be done monthly and the QA nurse will give direct feedback to the MDS coordinator on any deficiencies found in the care plan. Quarterly findings will be reported to the QA committee.	

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F 323	Continued From page 4 Medical record review of the Minimum Data Set (MDS) dated August 5, 2010, revealed the resident had impaired short/long term memory, total dependence for ambulation, and required two plus persons assist for transfers. Medical record review of a Fall Risk Assessment dated August 2, 2010, revealed the resident at risk for falls. Medical record review of the Assisted Transfer Policy revealed "...If the resident cannot stand alone, two persons (one on each side) should assist the resident to stand using a gait belt, and turn the resident and sit him/her in the chair..." Medical record review of a Nurse's Notes dated September 27, 2010, revealed "...Resident failed to bear weight et (and) assisted to floor during transfer from shower chair to wheelchair..." Continued medical record review revealed no documentation that a gait belt had been used for the transfer. Interview with Licensed Practical Nurse #4, on December 1, 2010, at 10:50 a.m., in the nurse's office confirmed the facility failed to follow the Assisted Transfer Policy and a gait belt had not been used to assist with a transfer on September 27, 2010.	F 323	Nursing staff was in-serviced on proper use of gait belts and assistive devices. The QA nurse and Director of Nursing will perform weekly checks with staff to observe for gait belts and use of assistive devices. necessary corrections will be made and the QA nurse will report findings to the quality assurance committee.	12/8/2010
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	<p>Continued From page 5</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to implement infection control practices to prevent the spread of infection for six (#6, #18, #26, #10, #13, #25) of twenty-six residents</p>	F 441			

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F 441	<p>Continued From page 6 reviewed.</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on November 5, 2010, and readmitted on November 23, 2010, with diagnoses including Respiratory Failure, Deep Venous Thrombosis, Alcohol Abuse, Supraventricular Tachycardia, Hepatitis B, and Failure to Thrive.</p> <p>Observation of the resident's room during initial tour on November 30, 2010, at 10:00 a.m., revealed a red biohazard bag (used for infectious waste) in the trash can and a biohazard/biodegradable bag in the linen hamper. Continued observation of the room revealed no signage to indicate the resident was on isolation. Further observation of the room revealed no evidence of personal protective equipment (gowns, masks) other than disposable gloves.</p> <p>Medical record review revealed no documentation the resident was on isolation.</p> <p>Review of facility policy Isolation Techniques revealed "Isolation signs should be placed on the door of rooms where residents receive isolation precautions. The sign should inform visitors, Do Not Enter Room - Report to the Nurse's Station for instructions." Further review of the policy revealed "Contact Isolation is designed to prevent transmission of highly transmissible or epidemiologically important infections...All diseases or conditions included in this category are spread primarily by close or direct contact. Thus mask, gown, and gloves are recommended for anyone in direct contact with any resident who has an infection that is included in this category."</p>	F 441	<p>Primary care physician for resident # 6 was contacted and order written for contact isolation. Sign was placed outside of resident's room immediately with additional signs available to nursing staff in all crash carts in facility. Mask, gowns, and gloves were placed outside of resident's room on a table. Disposable bags and Biohazard bags were placed on table outside of resident's room.</p> <p>Non-vital equipment was placed in the resident's room. Antiseptic solution and disposable gloves were placed in resident's room.</p> <p>The MDS coordinator updated the plan of care to reflect the necessity of isolation precautions for the resident.</p>		

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F 441	<p>Continued From page 7</p> <p>Interview with the DON (Director of Nursing) on December 2, 2010, at 9:00 a.m., in the DON's office, confirmed the resident was on contact isolation precautions for Hepatitis B and there was no sign on the resident's door indicating the resident was on isolation. Continued interview with the DON revealed gloves and masks were available at the nurses' station and gowns were available in central supply, but were not routinely stocked in the resident's room.</p> <p>Resident #18 was admitted to the facility on May 30, 2003, and readmitted on June 27, 2009, with diagnoses including Myelodysplastic anemia, Coronary Artery Disease, Gastroesophageal Reflux Disease, and Neurogenic Bladder.</p> <p>Medical record review of a physician's note dated August 9, 2010, revealed "C-diff (Clostridium Difficile) with copious watery, liquid, brown diarrhea." Continued medical record review of a physician's note dated September 14, 2010, revealed "C-diff culture positive."</p> <p>Further medical record review revealed no documentation the resident was placed on contact isolation precautions.</p> <p>Interview with the DON on December 2, 2010, at 9:30 a.m., in the DON's office, confirmed the resident was placed on contact isolation precautions for C-diff in stool.</p> <p>Interview with the Wound Care Coordinator on December 2, 2010, at 12:40 p.m., in the conference room, confirmed there was no documentation in the medical record to reflect the resident was placed on isolation precautions or</p>	F 441	<p>Resident #18 was not placed on isolation precautions again secondary to follow up lab work stating negative culture for C-diff on 9/12/2010.</p> <p>Nursing staff was in-serviced on the updated nursing procedure for contact isolation. Procedure states that the charge nurse obtain a physician order for contact isolation and must document this order for necessity of isolation precautions.</p>	

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F 441	<p>Continued From page 8 the type of precautions.</p> <p>Resident #26 was admitted to the facility on November 4, 2010, with diagnoses including Congestive Heart Failure, Coronary Artery Disease, Coronary Artery Bypass Graft, Diabetes Mellitus, Hypertension, Gastroesophageal Reflux Disease, and Transient Ischemic Attack.</p> <p>Medical record review of a nursing note dated November 21, 2010 at 4:00 p.m., revealed "Wound care done to posterior thigh. Dark red, purple area approx (approximately) 10 cm (centimeters) x 10 cm. Has area in center 2.5 cm x 2.5 cm with 2 pinpoint open areas with thick yellow drainage." Further medical record review of a nursing note dated November 23, 2010, at 8:50 a.m., revealed "...wound culture of resident received with MRSA (Methicillin Resistant Staphylococcus Aureus) in wound."</p> <p>Observation of the resident's room during initial tour on November 30, 2010, at 10:15 a.m., revealed no sign on the door indicating the resident was on isolation. Continued observation revealed a red biohazard bag in the trash can and a biohazard/biodegradable bag in the linen hamper. Further observation revealed no personal protective equipment in the room other than disposable gloves.</p> <p>Review of facility policy Isolation Techniques revealed "Isolation signs should be placed on the door of rooms where residents receive isolation precautions. The sign should inform visitors, Do Not Enter Room - Report to the Nurse's Station for Instructions."</p>	F 441	<p>Primary care physician for resident # 26 was contacted and order written for contact isolation. Sign was placed outside of resident's room immediately with additional signs available to nursing staff in all crash carts in facility. Mask, gowns, and gloves were placed outside of resident's room on a table. Disposable bags and Biohazard bags were placed on table outside of resident's room. Non-vital equipment was placed in the resident's room. Antiseptic solution and disposable gloves were placed in resident's room.</p> <p>The MDS coordinator updated the plan of care to reflect the necessity of isolation precautions for the resident.</p>		

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F 441	<p>Continued From page 9</p> <p>Interview with the DON on December 2, 2010, at 9:00 a.m., in the DON's office, confirmed the resident was on contact isolation due to MRSA and there was no sign on the resident's door indicating the resident was on isolation.</p> <p>Observation on November 30, 2010, at 2:10 p.m., revealed Licensed Practical Nurse (LPN) #1 providing wound care to resident #10. Observation revealed LPN#1 removed a dressing from a sacral wound, removed the gloves and washed the hands. Observation revealed LPN #1 applied two gloves to each hand and described the wound as a Stage IV pressure ulcer measuring 6.0 cm. (centimeters) in length and 5.0 cm. wide, with a slight amount of serous drainage. Observation revealed LPN #1 removed one glove from the right hand and cleaned the wound with wound cleanser and a gauze pad. Continued observation revealed LPN #1 removed one glove from the left hand and cleaned the perimeter of the wound with wound cleanser and a gauze pad, applied a medicated dressing to the wound bed then applied a hydrocolloid dressing to the wound. Observation revealed LPN #1 removed the gloves and without washing the hands, reapplied gloves and provided incontinence care to the resident after an episode of fecal incontinence. Continued observation revealed LPN #1 changed the gloves without washing the hands and applied cleans linens to the resident's bed, then removed the gloves and washed the hands.</p> <p>Review of the facility's policy Hand Washing revealed "...Hand washing should be performed between procedures..."</p>	F 441	<p>The Director of Nursing and Quality Assurance Nurse will monitor infections through the infection monitor sheet and charge nurses have been in-serviced to notify the QA nurse when any new infection arises that is communicable. This will ensure that all infection control measures are in place.</p> <p>Tracking of facility infections will continue with the Director of Nursing and the QA meeting will discuss the adherence to new procedure for contact isolation precautions for the quality assurance program in facility. The facility will include Infection Control in the Safety In-Services and meetings.</p>	12/8/2010	

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F 441	Continued From page 10 Interview on December 2, 2010, at 8:55 a.m., with the Director of Nursing (DON), in the DON's office, revealed the hands were to be washed and after cleaning a wound prior to applying a clean dressing. Interview on November 30, 2010, at 3:00 p.m., with LPN #1, in the nursing office, revealed the hands were to be washed after providing wound care and after providing incontinence care. Continued interview confirmed the hands were not washed after cleaning the wound prior to applying a clean dressing, after providing wound care prior to providing incontinence care, and after providing incontinence care prior to placing clean linens on the resident's bed. Observation on November 30, 2010, at 11:20 a.m., during a medication pass on Wing 3, revealed LPN #2, with gloved hands, entered the room of resident #13. Further observation revealed LPN #2 did not wash hands prior to removing a bottle of Neomycin, Polymixin B, Hydrocortisone (Cortisporin) Ophthalmic Suspension (antibiotic medication for eye infection) from a plastic bag previously stored in the Wing 3 Men's medication cart. Further observation revealed LPN #2, with gloved hands, left the resident's bedside to lock Wing 3 Men's medication cart, located at the entrance of the resident's room; returned to the resident's bedside; held the bottle of Neomycin, Polymixin B, Hydrocortisone (Cortisporin) Ophthalmic suspension in the gloved hands; administered two drops to each eye of resident #13; removed the gloves from hands; and exited the room without washing hands after administering the eye drops.	F 441	The facility policy on Hand Washing now includes Hand Hygiene. The facility will continue following the hand washing protocol between procedures but will allow the use of hand sanitizer and hand hygiene or hand washing between procedures. This policy was updated and put into place on the day the staff was in-serviced on the new policy. The QA nurse and/or Director Of Nursing will observe the wound care nurse perform wound care as part of QA rounds on a weekly basis. Compliance and proper technique will be observed according to facility procedure and policy. The quality assurance committee will be informed of findings and follow up on any corrections or suggestions to meet compliance.		12/8/2010

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/02/2010
NAME OF PROVIDER OR SUPPLIER OVERTON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 318 BILBREY STREET LIVINGSTON, TN 38570		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	<p>Continued From page 11</p> <p>Review of manufacturer's specifications for Cortisporin Ophthalmic Suspension revealed "Information for Patients...ocular products, if handled improperly, can become contaminated by common bacteria known to cause ocular infections. Serious damage to the eye and subsequent loss of vision may result from using contaminated products..."</p> <p>Review of facility policy Eye Ointment/Drops Administration revealed "...PURPOSE To administer ophthalmic ointment/drops into and around the eye, in a safe and accurate manner. STANDARD...3. Explain procedure to resident. 4. Wash hands (examination gloves may be applied)...9. Instill medication...15. Wash hands..."</p> <p>Interview with LPN #2 on November 30, 2010, at 11:30 a.m., at the Wing 3 Men's medication cart outside the room of resident #13, confirmed the hands were not washed before and after the administration of eye drops to resident #13 and gloved hands were contaminated when touching the plastic storage bag previously located on the medication cart and when touching the medication cart prior to the administration of the eye drops.</p> <p>Interview with the Director of Nursing (DON), on December 1, 2010, at 1:30 p.m., in the DON's office confirmed hands are to be washed before and after administering eye drops to residents per facility policy and not contaminated prior to administering eye drops to any resident.</p> <p>Observation on November 30, 2010, at 3:17 p.m., during a medication pass on Wing 2, revealed LPN #3, with gloved hands, entered the room of</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER OVERTON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BILBREY STREET LIVINGSTON, TN 38570		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 12 resident #25. Further observation revealed LPN #3 did not wash hands prior to removing a bottle of Dorzolamide and Timolol (Cosopt) Ophthalmic Solution (medication for glaucoma) from a plastic storage bag previously stored in the Wing 2 Long Hall cart. Further observation revealed LPN #3 administered one drop of ophthalmic medication to each eye of resident #25; removed the gloves; and exited the room without washing hands after the administering the eye drops. Interview with LPN #3, on November 30, 2010, at 3:25 p.m., at the Wing 2 Long Hall cart located outside the room of resident #25 confirmed the hands were not washed before and after the administration of eye drops to resident #25 and gloves were contaminated after touching the plastic medication bag prior to administering the eye drops. Interview with the DON, on December 1, 2010, at 1:30 p.m., in the DON's office confirmed hands are to be washed before and after administering eye drops to residents per facility policy and not contaminated prior to administering eye drops to any resident.	F 441	Nurses # 1, #2 and #3 were present for the in-service on the updated policy and procedure for hand washing/hand hygiene. The in-service was held with nursing staff and questions and answers were discussed concerning proper procedure. The QA nurse will observe nursing staff during weekly compliance rounds to observe if proper procedure is being followed and staff will be in-serviced as needed and re educated as needed.		
F 514 SS=D	C/O #27122 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514	The Quality Assurance Committee will be informed of findings of compliance rounds and follow up on any corrections or suggestions to meet compliance.	12/8/2010	

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NAME OF PROVIDER OR SUPPLIER OVERTON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 318 BILBREY STREET LIVINGSTON, TN 38570		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 13</p> <p>information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to maintain a complete and accurate clinical record for one resident (#20) of twenty-six residents reviewed.</p> <p>The findings included:</p> <p>Resident #20 was admitted to the facility on February 23, 2009 with diagnoses including Dementia, Psychosis, Benign Prostatic Hypertrophy, and Atrial Fibrillation.</p> <p>Medical record review of the monthly recapitulation orders dated November and December 2010 revealed the resident's Code Status as "Full Code" (Resuscitate/CPR).</p> <p>Medical record review of the resident's POST (Physician Orders for Scope of Treatment) dated October 22, 2010, revealed the resident's Code Status as "Do Not Resuscitate (DNR/no CPR)."</p> <p>Interview with the Director of Nursing on December 2, 2010, at 10:30 a.m., in the conference room confirmed the resident's medical record was not updated to reflect the resident's current code status.</p>	F 514	<p>Resident # 20 physician orders were updated to reflect DNR status. To reflect changes in Status of residents the Facility implements A "change of status" form. This form will now include Code Status and be passed to departments which can update this information. Nursing staff was In-serviced on this procedure, the Social Services Director will write the status on the change of status</p>		